A Further Look at Health Disparities: Lessons Learned from the Health Enterprise Zones

Building Success of Evidence-Based Community Programs

September 7, 2016

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MISSION AND VISION

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

What is a Health Enterprise Zone (HEZ)?

- A designated local community with documented poverty, health disparities and/or poor health outcomes, where special incentives and funding streams are available to address poor health outcomes by using healthcare-level, community-level and individual level interventions.

- Created through the MD Health Improvement and Disparities Reduction Act of 2012

- There are 5 HEZs in MD, based at:
  - Anne Arundel Medical Center (suburban)
  - Prince George's County Health Department (suburban)
  - Bon Secours Hospital (urban)
  - Caroline/Dorchester County Health Departments (rural)
  - MedStar St. Mary's Hospital (rural)

Maryland Health Improvement & Disparities Reduction Act of 2012

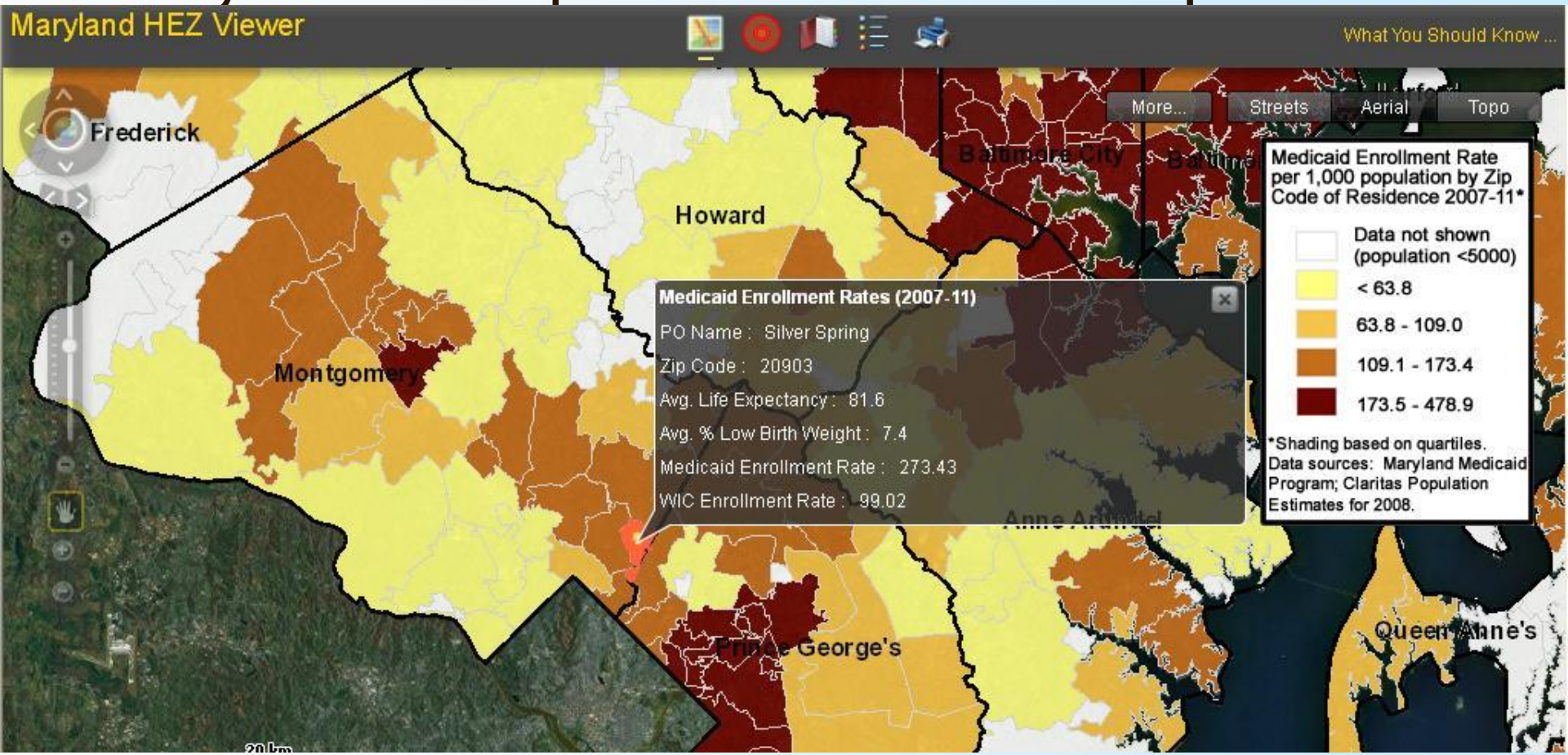
- Health Enterprise Zones
- Hospitals report efforts to reduce Disparities
- Standard measures on racial and ethnicity in quality and outcomes to track health insurance carriers' and hospitals' efforts to combat disparities.
- State institutions of higher education that train health care professionals are required to report to the Governor and General Assembly on their actions aimed at reducing health disparities.

HEZ Eligibility Criteria

1) An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes).
2) An HEZ must have a resident population of at least 5,000 people.
3) An HEZ must demonstrate greater economic disadvantage than MD average:
   - Medicaid enrollment rate or
   - WIC participation rate
4) An HEZ must demonstrate poorer health outcomes than MD average:
   - A lower life expectancy or
   - Percentage of low birth weight infants

Eligibility Criteria and Data

Based on these criteria DHMH developed dynamic maps with data at the zip-code

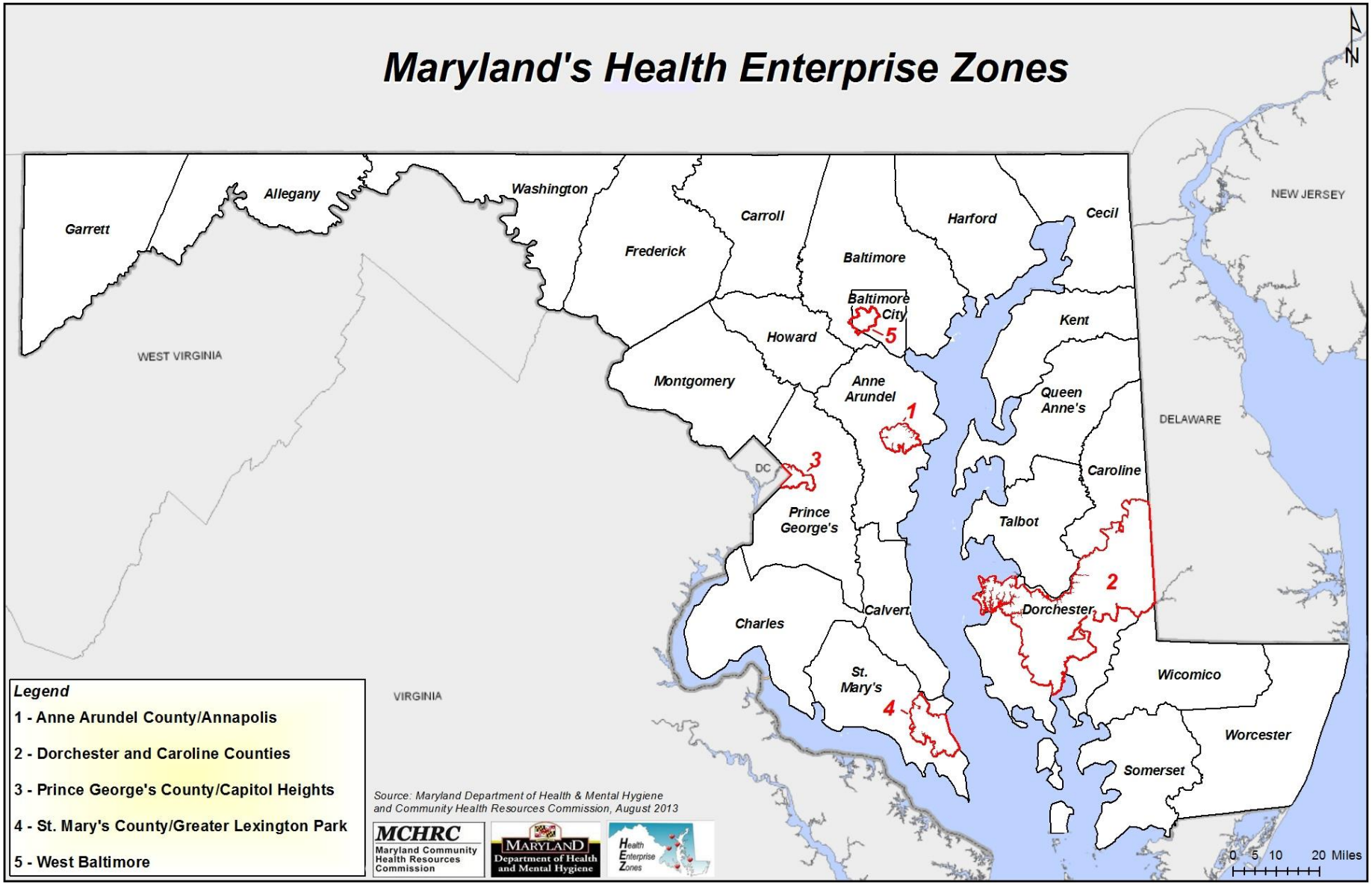


HEZ Designations

- Call for Proposals, developed October 2012, generated 19 applications from 16 jurisdictions
- Five HEZs were designated in January 2013 from rural, urban, and suburban areas. Three are led by coalitions of hospitals/health systems and two are led by local health departments

MARYLAND
Department of Health and Mental Hygiene

Maryland's Health Enterprise Zones



Legend

1 - Anne Arundel County/Annapolis

2 - Dorchester and Caroline Counties

3 - Prince George's County/Capitol Heights

4 - St. Mary's County/Greater Lexington Park

5 - West Baltimore

Source: Maryland Department of Health & Mental Hygiene and Community Health Resources Commission, August 2013

MCHRC Maryland Community Health Resources Commission

MARYLAND Department of Health and Mental Hygiene

Health Enterprise Zones

MHHD Logic Model Incorporated into HEZ

- The MHHD Logic Model has six key strategies that are generally applicable to programs.
- These six strategies became HEZ principles:
  - Cultural, linguistic and health literacy competency
  - Workforce diversity
  - Outreach to and targeting of minority populations
  - Racial, ethnic & language data collection/reporting
  - Addressing social determinants of health
  - Balance between provider and community focus

Health Enterprise Zones

Legislative Expectations (from the Statute)

20–1402.

- (A) THE PURPOSE OF ESTABLISHING HEALTH ENTERPRISE ZONES IS TO TARGET STATE RESOURCES TO REDUCE HEALTH DISPARITIES, IMPROVE HEALTH OUTCOMES, *AND REDUCE HEALTH COSTS AND HOSPITAL ADMISSIONS AND READMISSIONS* IN SPECIFIC AREAS OF THE STATE. (Page 5)

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Maryland Prevention Quality Indicators by Race and Ethnicity with Black % excess
http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80

Ambulatory Care Measures	Whites (Non-Hisp)	Blacks (Non-Hisp)	B/W Ratio	Rank	B-W Differ	Rank	Black % excess
Respiratory Disease							
Admissions for chronic obstructive pulmonary disease per 100,000 population, age 18 and over	190.8	179.19	0.94	14	-11.61	14	N/A
Bacterial pneumonia admissions per 100,000 population, age 18 and over	260.11	355.93	1.37	10	95.82	7	26.9%
Pediatric asthma admissions per 100,000 population, ages 2-17	95.98	294.09	3.06	3	198.11	3	67.4%
Asthma admissions per 100,000 population, age 18 and over	115.34	312.68	2.71	6	197.34	4	63.1%
Asthma admissions per 100,000 population, age 65 and over	262.86	519.71	1.98	9	256.85	2	49.4%
Immunization-preventable influenza admissions per 100,000 population, age 65 and over	23.51	24.33	1.03	13	0.82	13	3.4%
Heart Disease							
Admissions for hypertension per 100,000 population, age 18 and over	44.39	200.66	4.52	2	156.27	6	77.9%
Admissions for congestive heart failure per 100,000 population, age 18 and over	351.43	896.83	2.55	7	545.40	1	60.8%
Admissions for angina without procedure per 100,000 population, age 18 and over	47.82	65.07	1.36	11	17.25	11	26.5%
Diabetes							
Admissions for diabetes with short-term complications per 100,000 population, ages 6-17	20.56	22.25	1.08	12	1.69	12	7.6%
Admissions for diabetes with short-term complications per 100,000 population, age 18 and over	46.09	134.31	2.91	4	88.22	8	65.7%
Admissions for diabetes with long-term complications per 100,000 population, age 18 and over	101.61	291.09	2.86	5	189.48	5	65.1%
Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over	10.09	46.72	4.63	1	36.63	10	78.4%
Lower extremity amputations among patients with diabetes per 100,000 population, age 18 and over	27.44	64.46	2.35	8	37.02	9	57.4%

HEZ Programmatic Elements

- Operational Model:
  - Coordinating Organization Manages Program
  - Hospitals, Clinics, CBOs, FQHCs
  - Application must target investments to the community
  - Must involve target audience and local assets
  - Metrics must measure change in specific outcomes

- State Health Department and Community Health Resources Commission jointly provide technical assistance:
  - Prevention and Health Promotion program support: Chronic Disease
  - MHHD office provides cultural competency training
  - Virtual Data Unit: Clinical data, CRISP data, data analysis
  - Health Systems Infrastructure Administration: Loan Repayment and Income Tax Credit

HEZ Incentive Program

- HEZ enabling legislation provides a number of incentives and resources to attract providers to the Zones:
  - State income tax credits
  - Hiring tax credits
  - Grants for program support, equipment purchase or lease
  - Loan repayment assistance programs
- Practitioners must meet the following criteria to access tax credits:
  - Cultural competency training
  - Accept Medicaid and uninsured patients
  - Letter of support from the Coordinating Organization

HEZ Logic Model

Maryland Department of Health and Mental Hygiene

Strategy 1: Increase care capacity (defined as available clinical care visit appointment slots).
(People without primary care now get that care)
Measurement: added providers, added FTE of providers, added new visit slots, *(capacity)*; proportion of new capacity that is being used, visits/hour for new providers *(productivity)*
Reach: Small

Goal: Reduce Potentially Avoidable Utilization (PAU)
Measurement: ED visit rates, hospital admission rates, readmission "rates" *(outcomes)*

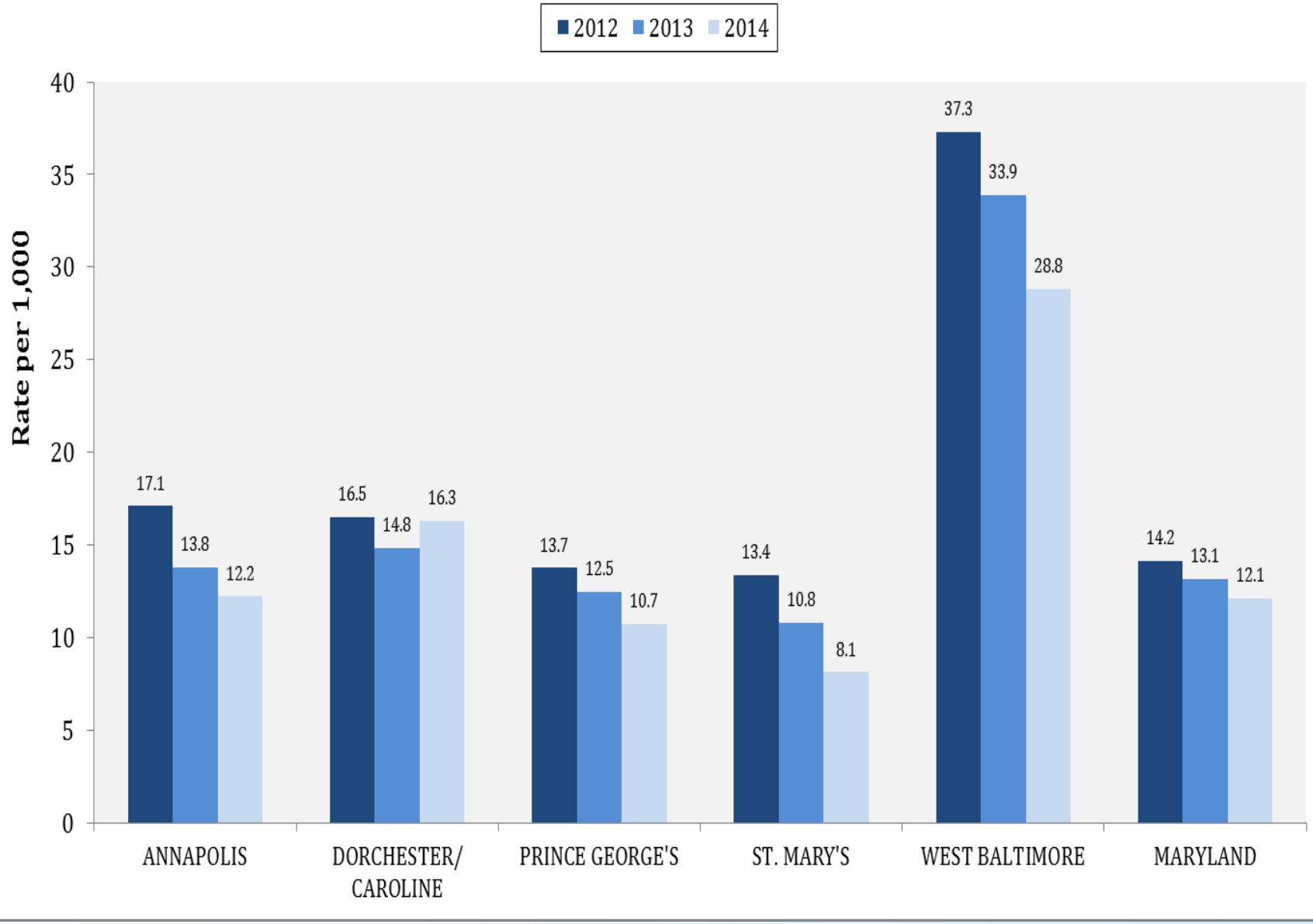
Strategy 3: Increase patient self-management ability (education, home visits, case managers, CHW).
(People who get care stay healthier at home)
Measurement: added workers and FTE of workers, available caseload *(capacity)*; Proportion of available caseload that is filled, encounters per worker *(productivity)*; Quality metrics for workers if such exist.
Reach: Small to Medium

Strategy 2: Increase care quality (defined as NQF or similar metrics).
(People in primary care get better care)
Measurement: NQF or equivalent metrics
A) Provider guideline adherence metrics *(quality)*
B) Patient disease control metrics *(outcomes)*
Reach: Medium

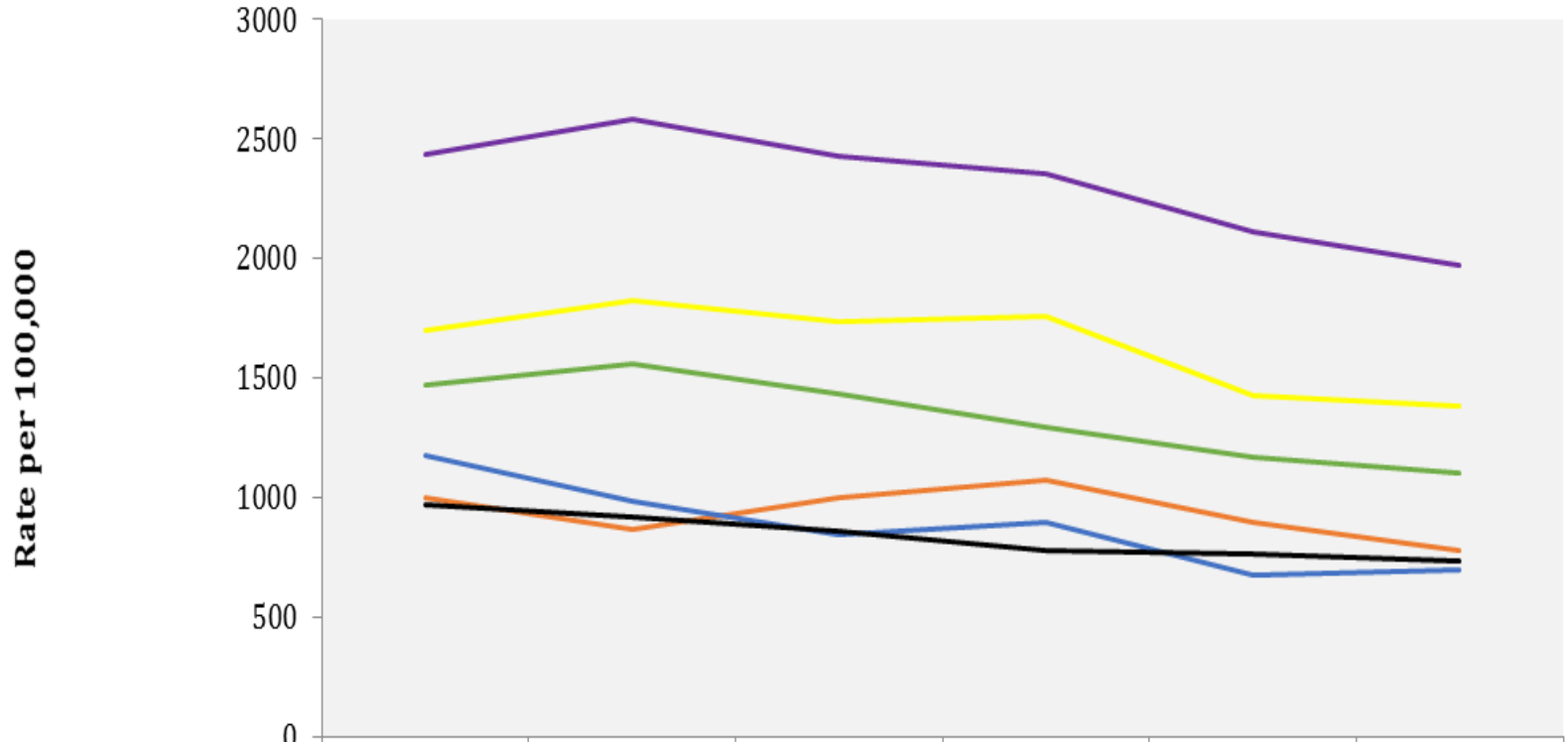
Strategy 4: Community-wide enabling interventions.
This includes healthy food access, safe exercise, and any other intervention where users cannot be counted.
Reach: Large, but impact may be small

Domains and Timing:
- Year 1: Hire providers/workers (cap)
- Year 2: Fill capacity (productivity)
- Year 3: Assure quality
- Year 4: Demonstrate outcomes

All-Cause Unplanned Readmission Rates, 2012-2014.

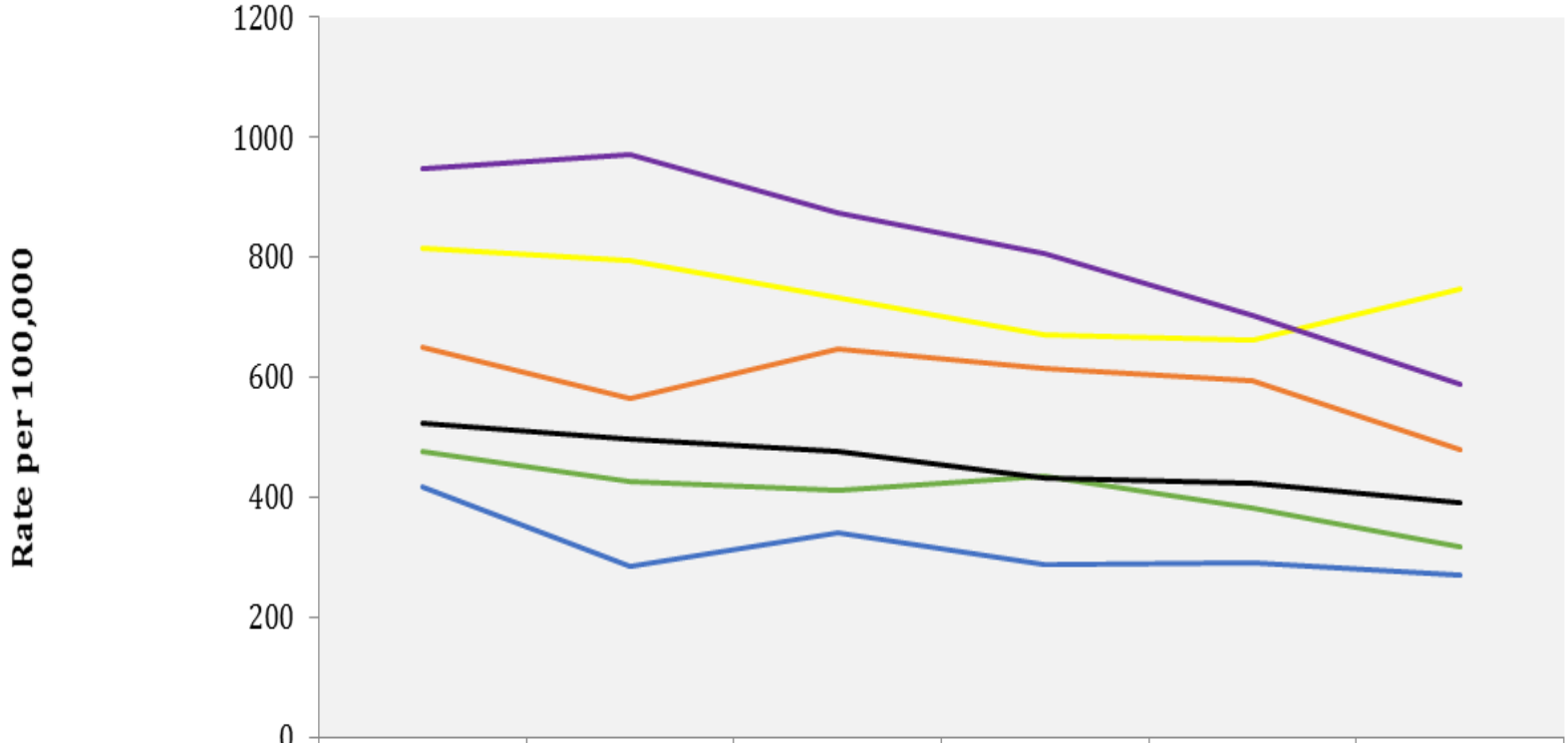


Prevention Quality Indictors (PQI) Chronic Composite, 2009-2014.



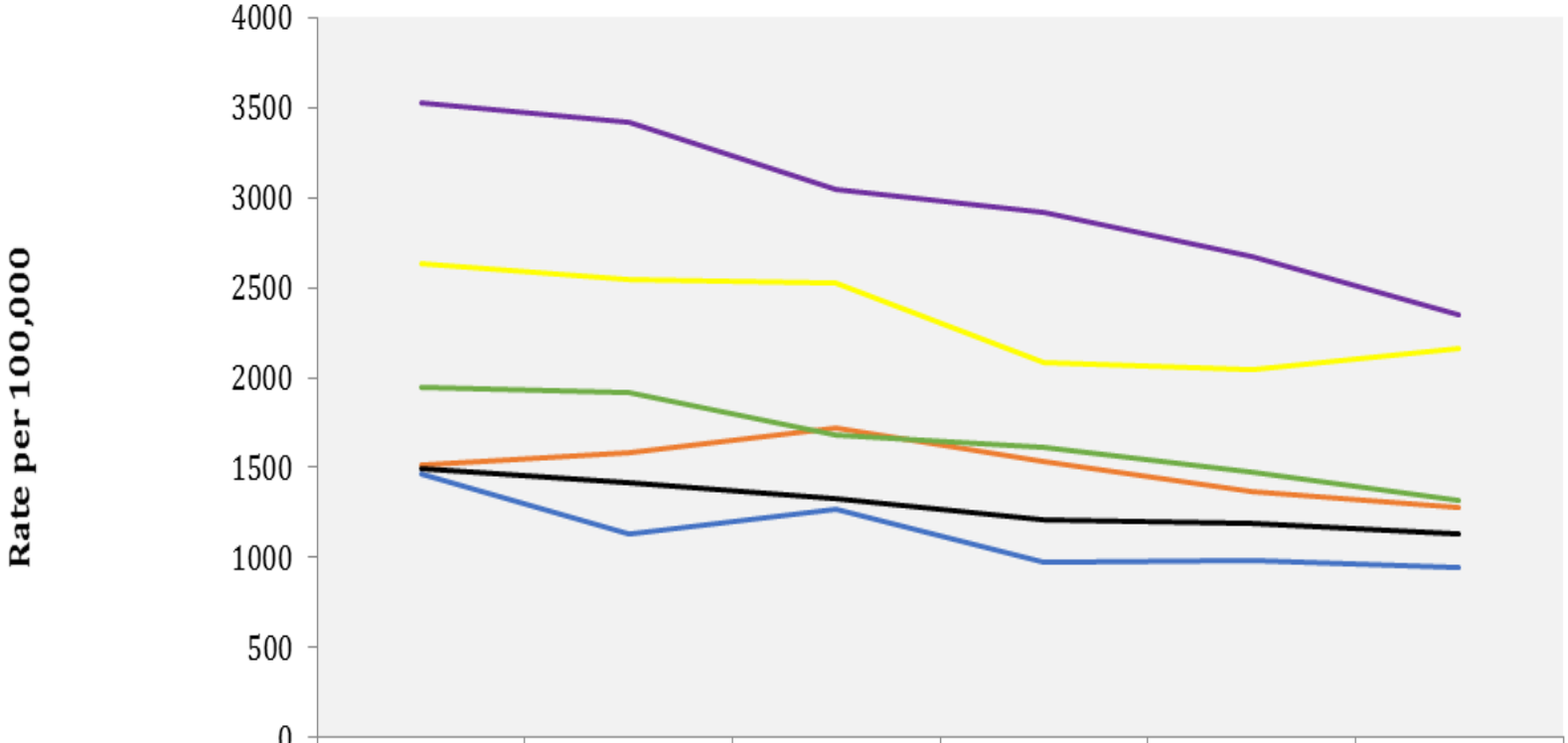
	2009	2010	2011	2012	2013	2014
ANNAPOLIS	1001.4	862.7	997.3	1070.5	895.1	774.0
DORCHESTER/CAROLINE	1696.1	1826.5	1737.2	1753.6	1425.8	1383.4
PRINCE GEORGE'S	1469.2	1558.1	1435.0	1294.5	1168.7	1099.3
ST MARY'S	1176.7	986.8	840.0	893.2	674.7	697.1
WEST BALTIMORE	2433.9	2579.2	2425.3	2351.6	2111.3	1966.9
MARYLAND	971.4	920.2	854.6	775.7	766.1	736.0

Prevention Quality Indictors (PQI) Acute Composite, 2009-2014.



	2009	2010	2011	2012	2013	2014
ANNAPOLIS	649.1	564.1	647.7	614.0	595.0	479.1
DORCHESTER/CAROLINE	813.3	794.4	731.7	671.7	662.0	748.2
PRINCE GEORGE'S	477.3	427.1	409.6	434.9	381.9	317.4
ST MARY'S	417.4	284.6	339.1	287.9	290.8	268.4
WEST BALTIMORE	946.6	970.9	872.7	805.4	701.8	588.4
MARYLAND	522.3	495.5	477.1	432.3	422.1	391.2

Prevention Quality Indictors (PQI) Overall Composite, 2009-2014.



	2009	2010	2011	2012	2013	2014
ANNAPOLIS	1514.6	1581.6	1715.5	1537.8	1369.0	1274.2
DORCHESTER/CAROLINE	2636.8	2542.5	2529.4	2088.0	2048.1	2165.4
PRINCE GEORGE'S	1946.5	1914.0	1681.8	1615.5	1473.7	1316.1
ST MARY'S	1466.0	1135.3	1267.7	969.6	985.8	945.1
WEST BALTIMORE	3531.4	3417.8	3041.7	2920.4	2672.6	2351.5
MARYLAND	1493.7	1415.7	1331.7	1208.0	1188.2	1127.2

- The Annapolis Community Health Partnership

ACHP
Intervention Strategy and Goals

•Collaboration between Anne Arundel Medical Center and the Housing Authority of the City of Annapolis to insert a community health resource in public housing to serve the building's residents *and the surrounding community* in two ways:

- Primary care medical services at reduced cost to the residents of the building and surrounding community
- Navigational services for all at no cost: care coordination, coaching, education, advice, and support

•Primary Goal: Provide culturally and linguistically appropriate primary care services to the Morris Blum residents and surrounding community.

•Secondary Goal: Measurably reduce 911 calls, ED visits, admissions, readmissions of Morris Blum residents.

What Works

- On demand services
- Team-based care: it's NOT all about the doctor!
- Fun health education events: it's all about THEM!
- Relationship building-trust
- Psychosocial needs competently identified and addressed
- Home visits
- Navigational services
- Medication Therapy Management
- Health coaching
- Tobacco Cessation Counseling

What Works-continued

- Referral for Recovery Program-network of (6) behavioral health providers-ability to connect patients in need of mental health services obtain an appointment within 48 hours of referral
- Integrated EMR and supportive specialist community
- Build traditional and non traditional community partnerships to meet the non-medical needs-housing, EMS, police, food bank, etc.
- Team interview and team decision to hire candidates who want to join our team
- Welcoming, forgiving, tolerant atmosphere: NO JUDGEMENT-patients-family and staff!
- Ongoing staff training/coaching

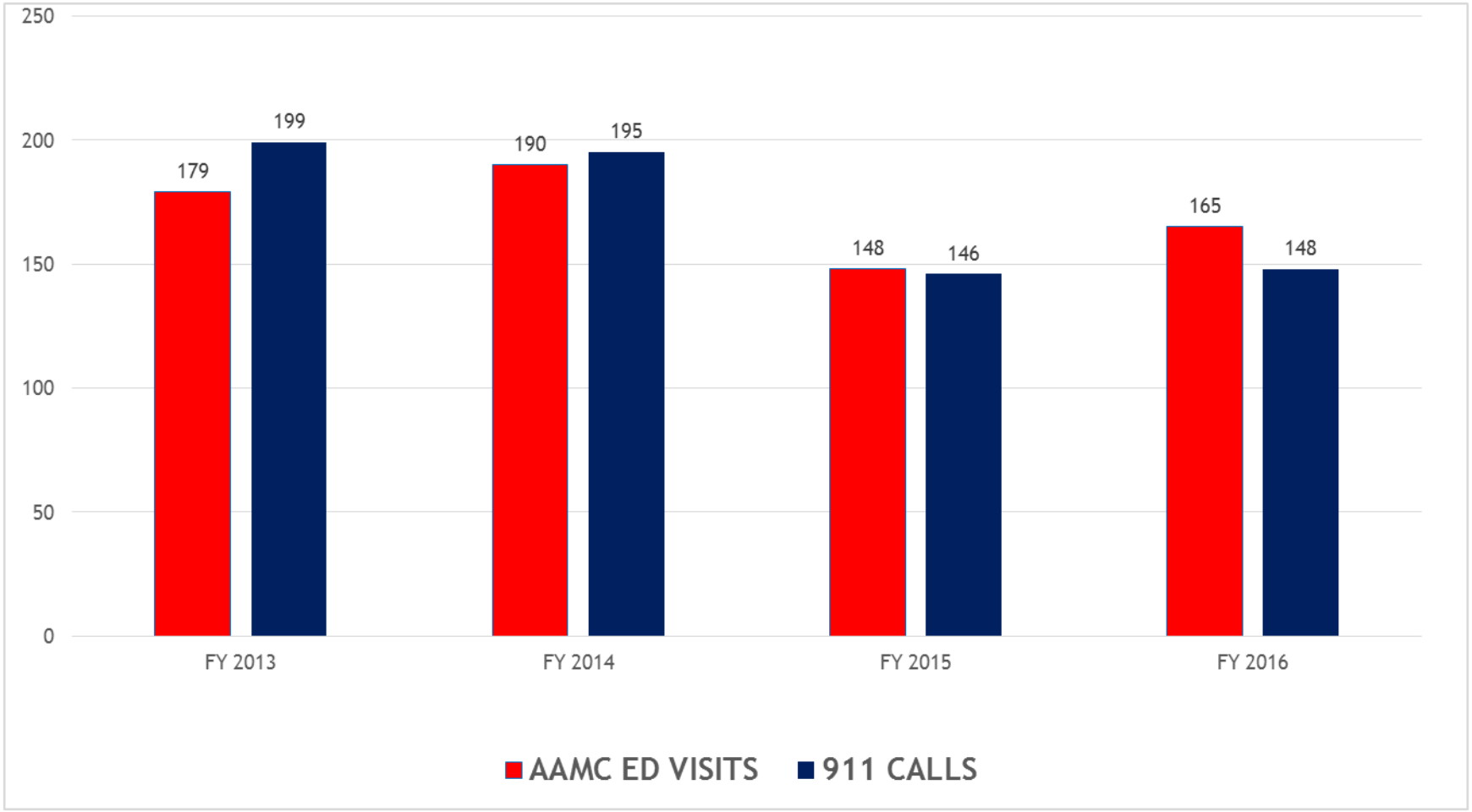
What Works-continued

- Specialized staff training
  - CLAS standards
  - Crisis Prevention Intervention (CPI)
  - Team based training
  - Medical Assistant Training provided by our Essential Skills Team 2-3 times per year
- Annual staff retreat
- Team huddles (daily)
- Humor

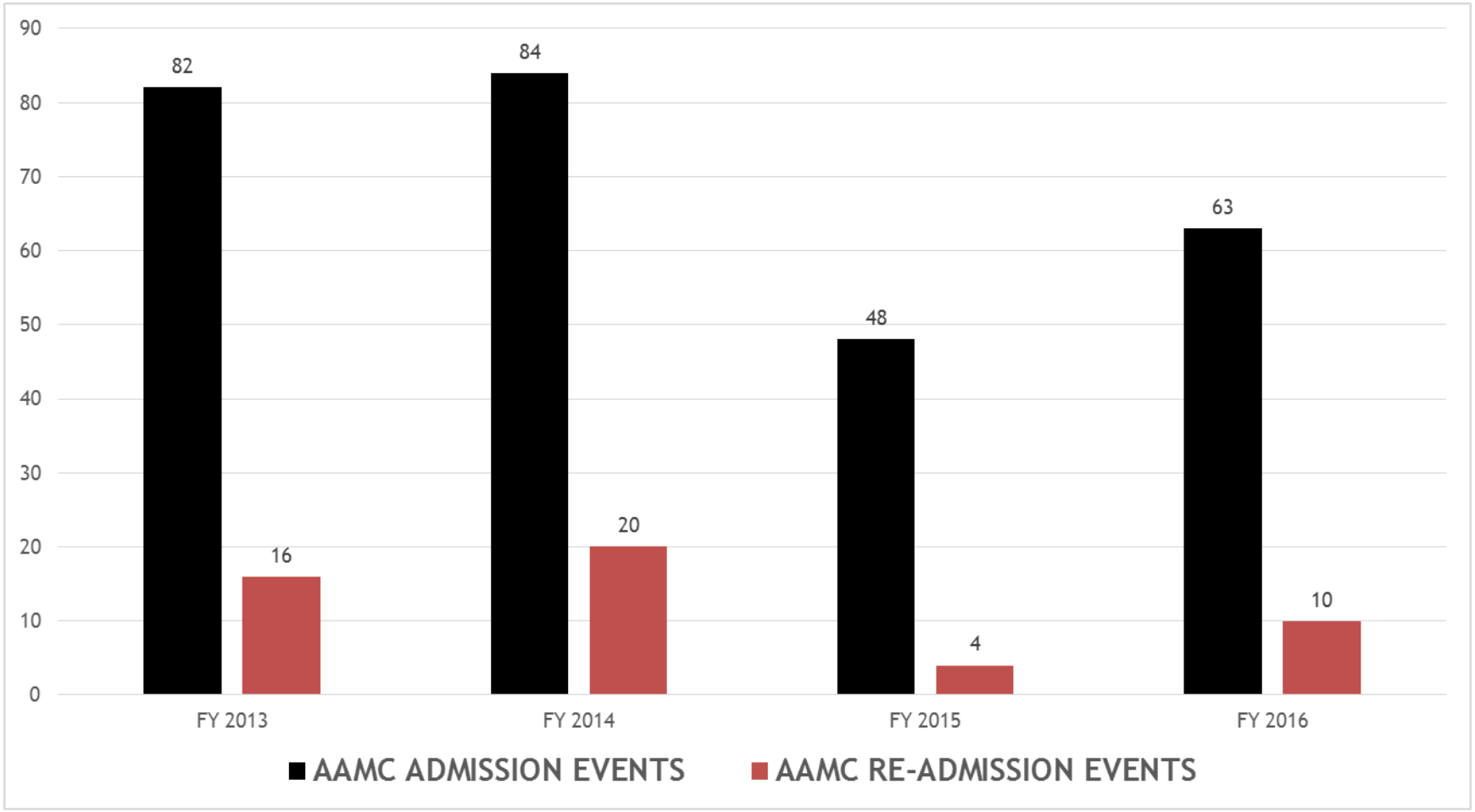
Lessons Learned

- Just because you build it does not necessarily mean they will come! Trust and consistency are essential
- Inter-cultural conflicts can be overcome
- Newly insured individuals need to be oriented and navigated
- Awareness and respect of a primary care clinic sharing space in a residential apartment building-we are in their living room
- Importance of hiring staff (all levels) that have passion and the skill set to work with a marginalized population

AAMC ED Visits and 911 Calls



AAMC Admission-Re-Admission Events



Summary

- Right care is given at the right time in the right place, thus improving quality and cost-effectiveness of care.
- Chronic disease in marginalized populations is identified and treated earlier, thus decreasing preventable, costly complications.
- A trusted, community-based health care resource provides a better alternative to the ED.

St. Mary's County Department of Social Services

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HELP FOR TODAY; HOPE FOR TOMORROW

SMCIL
Southern MD Center for Independent Living

ST. MARY'S COUNTY MARYLAND 1637

Minority Outreach Coalition

GREATER Baden Medical Services
Taking care of our community

HASMC

Greater Lexington Park Health Enterprise Zone (HEZ) Project

AccessHealth
Wellness within reach.

MedStar St. Mary's Hospital

Lori Werrell
Program Director, GLPHEZ
MedStar St Mary's Hospital

St. Mary's County Department of Social Services

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Vision

Establish accessible, integrated, culturally competent healthcare in the HEZ supported by clinical care coordination, prevention services, community outreach and education

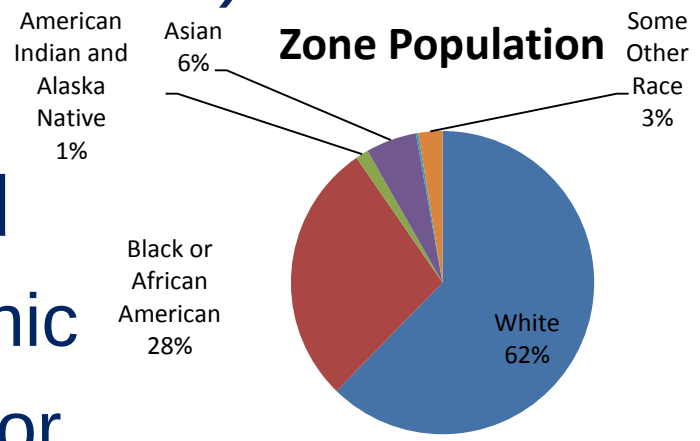
Core Disease States

Diabetes, Asthma, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Behavioral/Mental Health Diseases

MedStar St. Mary's Hospital

HEZ Demographics

- Population of approximately 34K in 3 zip codes (20653,20634,20667)
- Clients being assisted
  - 31% identify as Hispanic
  - 46% identify as Black or African American



Approximately 7% identify as Hispanic

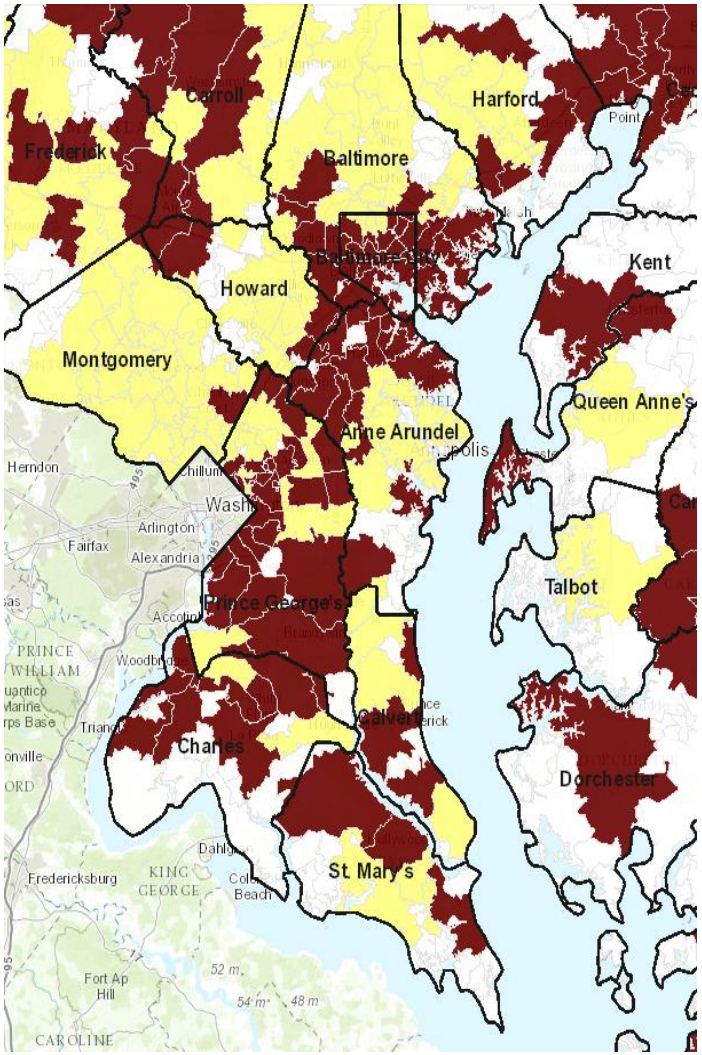
Greater Lexington Park Health Enterprise Zone

- **Lexington Park:**
  - Life Expectancy: 77.6 (lower than 79.1 years eligible)
  - Medicaid Enrollment: 200.93 (higher than 109.1 per 1000 eligible)
  - WIC participation: 38.77 (higher than 18.0 per 1000 eligible)
- **Great Mills:**
  - Average % low birth rate: 7.4 (higher than 6.4 per 1000 births eligible)

    Medicaid enrollment: 128.84

    WIC participation: 20.49

**Needed to meet either life expectancy or low birth weight and Medicaid enrollment or WIC participation thresholds.



Major Program Components

Hospital encounter
- Inpatient (readmission risk factors triggers Care Coordinator)
- Emergency Room (follow up by Community Health Worker

Care Coordinator
- Home visits, care plans, phone support, medication reconciliation
- Working with other care coordination programs and primary care

Community health worker
- Removing Barriers (Their training is offered to whole community)
- Transportation (shuttle and medical specialty routes)

Outpatient Care
- Primary and specialist appointments, Dental
- PT ,Dialysis, Cardiac Pulmonary Rehab etc

Self management programs
- Walk with Ease, CDSMP, NDPP, diabetes self management program, support groups, Walden Sierra programs

Success in Year 3

- Readmission rate of RN Care Coordinated patients - 7.03%
  - State data has the whole zone Readmissions rate dropping from 13% to 8% (36.9% drop)
  - Emergency Room Visits are down
  - PQI Composite scores are below state averages

- # of new clients served by CHWs – 271
- # of client encounters with CHWs – 4421

- Shuttle ridership – 7497
- Medical Specialty rides – 440

- # of patients served by Walden for behavioral Health – 656
- # of unduplicated Psychiatric patients seen by Walden – 87
- # Dental patients seen – 42
- # Primary Care patients seen - 2105

Year 4 Focus

- Sustainability
- Care Coordination/CHW program
- Transportation
- Dental
- Behavioral Health
- Health Center/Primary Care/Psychiatry
- Provider recruitment

Lessons Learned

- Don’t be afraid to change from the original plan
- Take risks
- Data – blessing and a curse
- Be patient – don’t stop trying
- Listen to the community
- Staffing
- Vehicles

AccessHealth
Wellness within reach.

Health Center Building under Construction - FINALLY

St. Mary's County Department of Social Services

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QUESTIONS?

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PREVENTION AND HEALTH PROMOTION ADMINISTRATION

http://phpa.dhmh.maryland.gov